GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES
DEVELOPMENTAL DISABILITIES ADMINISTRATION

PSYCHIATRY APPOINTMENT CONSULT FORM

Person's Name:	**Appointment Date:**
Date of Birth:	**Age:**
Residential Provider:	**Residential Provider Contact:**
Day Services Provider:	**Day Services Contact:**
Physician's Name:	**Date of last quarterly Psychotropic Medication Review:**

(This section to be completed by prescriber)

DSM DIAGNOSIS:

IMPRESSIONS and RECOMMENDATIONS:

☐ **I find NO CHANGES ARE NEEDED. Continue current orders and recommendations.**

☐ **I find CHANGES ARE NECESSARY. Revised orders and recommendations are listed below.**

ORDERED PSYCHOTROPIC MEDICATIONS:

Please list [Medication; Dosage/Route/Frequency; Symptom targeted by medication; Psychiatric diagnosis targeted by medication]

LABS ORDERED TODAY (IF ANY) Metabolic screening/Labs/Diagnostic tests ordered:

FOLLOW UP APPOINTMENT DATE/ TIME:

Physician's Printed Name and Signature	**Date**
Physician:	